Executive Summary:

To date, few formal evaluations of crisis service models have been conducted. However, the few studies available do indicate that crisis services are a valuable resource for helping individuals with mental health issues in both rural and urban areas. This evaluation examined three police mobile crisis models: the police crisis models in place in the communities of Haldimand-Norfolk, Chatham-Kent, and Hamilton, to identify key issues pertaining to the development of crisis service programs across Ontario. Each model differed in terms of the relationship established between police and psychiatric crisis services. In Hamilton the police were part of the psychiatric crisis team, in Chatham Kent a psychiatric worker joined the police team, whereas in Haldimand-Norfolk the police and crisis services were distinct from each other and had a less formal working relationship.

Quantitative data collection included a description of the three communities. Chatham-Kent, Haldimand-Norfolk, and Hamilton contain rural and small urban cities with populations of 109,600 (2006 Statistics Canada), 112,100 (2006 Statistics Canada), and 531,000 thousand respectively (2006 Statistics Canada).Data on suicide rates in all three communities were examined. Chatham-Kent's suicide mortality rate in 1997 was 8.7 while in 2001 it was 7.4. In 1997, the suicide rate for both sexes in Chatham-Kent was 8.7 per 100,000 people according to Statistics Canada. The existing psychiatric resources varied between the settings. Hamilton serves as a regional resource area and includes many specialized services whereas Chatham-Kent has a psychiatric ward within a general hospital and community mental health programs but has few services for addictions while Haldimand-Norfolk has no psychiatric in-patient program but has well established community and addiction services.

Administrative data was requested from each crisis service. However, the data was not collected in a uniform manner and thus differences and discrepancies in the data arose. The consistent data found was in the context of the number of contacts and services experienced.

The HELP team collected the number of contacts by individuals accessing the service. According to their data, the number of people accessing the service rose from 122 in 1998 to 494 in 2007.

The Cast Team collected data from 2004 to 2008 regarding the number of contacts, the number of assessments, demographic information, and the reasons for contact. In 2007, there were 476 clients served by the program during the first six months. In 2007 there were 966 calls made in the first six months. Contacts were classified according to the reason why the contact was made such as; the manifestation of mental illness symptoms, relationship problems, and suicidal ideation. Suicidal ideation was the third most common reason for contact.

The COAST team is the largest of the three crisis services and collects data pertaining to the number of requests for service, responses to requests, services provided, referral sources, dispositions, and demographic information describing service users. In 2007, there were 2,171 requests made for services. The most prevalent diagnosis made by the COAST team was that of schizophrenia. However, the diagnostic categories used did not follow the format of the DSM-IVR and included terms such as "bullying, disruptive behavior and family dysfunction." The most prevalent presenting problem found in the study was that of suicidal ideation/threat which comprised 10% of all contacts.

The data collected indicates that HELP is experiencing a demand in growth, whereas CAST and COAST have been experiencing greater stability and hence predictability in demand. All three of the programs focus on crisis services.

Qualitative data collection included participant observation in the form of focus groups and job shadowing. The focus group sample included 143 focus group participants comprised of 46 consumers, 47 family members, and 50 individuals involved in the provision of services at various agencies. Overall, the date indicated that all three groups were satisfied. However, concerns were expressed by consumers and family members regarding the difficulties they experienced while trying to access services in the midst of a crisis. Transportation and busy phone lines were identified as being impediments to access. Transportation within rural communities and between rural and urban centres could create unsafe conditions. For example, one women was forced to hitchhike home in the middle of the night in winter without a coat after having been taken to another community by police, but released with no way home and no way of paying for an $80 cab fee. Consumers in the study indicated they wanted to access to peer support services as part of their crisis care. Consumers described the difference between a "hotline" type of emergency service which requires professional intervention and a "warm-line" type of emergency service which could include peer support. Providers in all areas regarded the crisis team and police as being a critical part of the care provided in psychiatric emergencies.

Participants in the focus groups completed questionnaires. The responses to these questionnaires revealed that consumer and their family members felt varying feeling of satisfaction with community crisis services. On the whole, they were satisfied with having crisis services but they were not satisfied with the scope of the services provided. Families reported feeling less satisfied and/or neutral about how they felt about crisis services whereas consumers agreed or somewhat agreed with the statement that they were satisfied with the quality of crisis services. Just over 50% of consumers and families reported feeling that crisis services had responded to their crisis in a timely manner. Two thirds of consumers and families agreed or somewhat agreed with the statement that crisis services were easy to access. The remaining one third of consumers and their families indicated that they somewhat agreed or disagreed with the statement that crisis services were easy to access. Many consumers and their families generally reported feeling positive and satisfied about crisis services while some consumers and their families continued to express neutral attitudes and/or a lack of satisfaction with current services. These findings reflect the need for a further evaluation of consumers' and family members' feelings of satisfaction with the delivery of crisis services.

Job shadowing took place at all three sites for two to five shifts per site. Research team members shadowed a team in each of the three communities. The research team members observed how police officers and crisis workers responded to both routine and crisis situations involving mental health consumers. These observations revealed how crisis services responded to specific missing pieces of the mental health system within their community. The issues were broad and demonstrated that crisis services were acutely involved in assisting in psychiatric issues related to relapse, addiction, psychogeriatrics and responding to issues of domestic violence. The program teams varied in the amount of outreach services versus intake services they provided.

The systems varied in their ability to provide consumers with quick access to psychiatric beds thus serving to reduce the wait times of both staff and consumers. Attempting to find a suitable hospital bed was very time consuming for teams without direct access to beds. This also created increased crowding in the emergency room and consumed many hours of police time. During one observation period, a police supervisor arrived at the emergency ward to determine why all but one cruiser was at the hospital. All of the involved police were with people awaiting psychiatric services leaving few policing resources available for two counties.

This indicates an urgent need for the provision of easy access to psychiatric beds. The effective functioning of crisis programs requires the provision of readily accessible psychiatric beds. One way to

response to this healthcare crisis would be the development of a centralized registry of available psychiatric beds, similar to existing registries pertaining to labor and delivery.

Since police officers are often called to resolve issues pertaining to individuals with mental health issues, they are often the first persons to come into contact with such individuals during a crisis. As a result, police officers often are the ones making the decision to bring individuals in crisis to hospital. Therefore, it is necessary for police departments to work collaboratively with community service agencies and hospital emergency departments.

Another important issue identified in the study was the need for more timely responses. When in crisis, consumers and their families wanted immediate help and became very frustrated when their calls for help went directly to an answering machine or a busy signal. Staffing issues typically give rise to these situations given that in each service, there were times when available staff could not respond to all the calls they were receiving. This finding suggests the need for the development of a coordinated telephone service in which neighbouring areas can serve as back up for each other.

In general, crisis services were found to be immensely valued in all three communities. This observation indicated that all crisis services utilized various partnerships which demonstrated the need for inter-agency collaboration, specifically, a working collaboration between police and mental health, community agencies, crisis services and emergency departments.